MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46

00727 245

Reg. Dist. No.

1. PLACE OF DEATH:

County: Prince Georges County

City or town: Berwyn Heights Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Berwyn Heights Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 8711 58th avenue,.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Albert Anderson

3. (b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Rose Anderson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 3, 1881-

8. AGE: Years	Months	Days	If less than one day
66	6	20	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Government service

FATHER

12. Name: Richard F. Anderson

13. Birthplace: Unknown

MOTHER

14. Maiden name: Susan Brown

15. Birthplace: Unknown

16. Informant: Mrs Rose Brown

Address: Berwyn Heights Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 26, 1948- (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Colmar Manor, Md.

18. Funeral director: F. Gasch's Sons

Address: Hyattsville Maryland.

19. Jan 26 1948 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 23, 1948 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 25 1947 to Jan 23 1948 and that I last saw h alive on Jan 22 1948

Immediate cause of death: Carcinoma Sigmoid

Due to: V Bladder

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION
10 m

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W B Lundmark M.D. or other

Address: Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00728

93e

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Fairmount Heights (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 yrs.
Hospital, institution, or street address where death occurred: 827 Eastern Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Fairmount Heights (If outside city or town limits, write RURAL and give nearest town)
Street No. 827 Eastern Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Edward Ashton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of ~~husband or~~ wife: Edith D. Ashton
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: 83 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Mrs. Edith D. Ashton
Address: 827 Eastern Ave.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 1/14/48 (month) (day) (year)
Cemetery or crematory
Location: Washington D.C.

18. Funeral director: Malson & Schey
Address: 424 R. St. N.W.

19. Jan. 14 1948 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 14, 1948 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 2 1948 to Jan. 14 1948 and that I last saw him alive on Jan. 13 1948

Immediate cause of death	DURATION
Congestive Heart Failure	
Due to: Senility & General Complications of Age.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: John W. Robinson, M.D. M. D. or other
Address: 1001 Eastern Ave. N.E. Date signed: 1/14/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00723

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CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Pro Geo Co.
City or town: Bowie Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pro Geo Co
City or town: Bowie Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Harry N. Bell

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: ?

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): unknown 1877

8. AGE: Years: 70? Months: Days: If less than one day: hrs. min.

9. Birthplace (Town, county, and state): Alabama

10. Usual occupation: Butcher

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Mary Weekerly
15. Birthplace: unknown

16. Informant: Mrs Andrew Gallagher
Address: Phila Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 8. 1948 (month) (day) (year)
Cemetery or crematory: Glendale Cemetery
Location: St. George Glendale Md

18. Funeral director: F. Gasche Sons
Address: Hyattsville Md.

19. 1/7 1948 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1 1948 at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 31 1947 to January 1 1948 and that I last saw him alive on January 1 1948

	DURATION
Immediate cause of death: Pulmonary Infarct, Left Lower Lobe	3 Days
Due to: Phlebothrombosis	1 week
Due to: Congestive Heart Failure	3 years
Other conditions: Arteriosclerotic Heart Disease	3 years
Varicose veins	10 years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Stephens, M.D. M. D. or other
Address: Laurel, Md. Date signed 1/1/48

00730

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Berwyn (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Moment

Hospital, institution, or street address where death occurred: Route #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No.: 809 King Street (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Windfield Scott Beall Jr

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Carolyn Beall

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): June 17, 1908

8. AGE: Years: 39 Months: Days: If less than one day: ... hrs. ... min.

9. Birthplace (Town, county, and state): Maryland

10. Usual occupation: Telephone repair man

11. Industry or business: Telephone

FATHER — 12. Name: W. S. Beall Sr.

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Grace White

MOTHER — 15. Birthplace: Maryland

16. Informant: Stanley W. Beall

Address: Silver Spring Md

17. Disposition: removal (Burial, cremation, or removal. Which?) Date thereof: Jan 6. 1947 (month) (day) (year)

Cemetery or crematory: Warner Pumphrey Funeral Home

Location: Silver Springs Md

18. Funeral director: F. Gaschi Sons

Address: Hyattsville Md.

Jan 6 1948 James Seery (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 1948 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive on ... 19...

Immediate cause of death	DURATION
Shock	
Due to: Third degree burns of the face, body	
Due to: extremities	

Other conditions (Include pregnancy within 3 months of death): Looked as though man had fallen asleep and had a lighted cigarette in his mouth that set upholstery on fire. (Dr. Boyd 2/4/48)

Major findings of operation: ... Date of op.: ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of: 1-6-48

Where did injury occur? Berwyn (City or town) P.G. (County) Md (State)

Injured at home, farm, industry, public place (where?): Route #1

Means of injury: Caught on fire Injured at work?

Deputy medical examiner

23. SIGNATURE: James E. Boyd M.D., or other

Address: Forestville Md Date signed: 1-6-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 00731

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George

City or town: District Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, Institution, or street address where death occurred: 313 Wash Bvd District Heights Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: District Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 313 Wash Bvd District Heights

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: BERTHA MAE BEAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: ALBERT T BEAN

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 16th 1889

8. AGE: Years 58 | Months 4 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace: Wilmington Delaware (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER 12. Name: J E Rigaler

13. Birthplace: Penna

MOTHER 14. Maiden name: Margaret Bryon

15. Birthplace: Penna

18. Informant: Albert T Bean

Address: 313 Wash Bvd District Heights Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof 1-23-48 (month) (day) (year)

Cemetery or crematory: Walsh. Mem.

Location: Suitland Md.

18. Funeral director: W W Chambers Co

Address: 517-11 st SE Wash DC

19. Jan. 21 1948 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 January 1948 at 2:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947 to Jan 20 1948 and that I last saw her alive on 20 Jan 1948

	DURATION
Immediate cause of death: Cardiac Vascular accident (Coronary thrombosis)	45 MIN.
Due to: Coronary arterio-sclerosis	2 years
Due to: Hypertensive arterio-sclerosis	10 yrs.
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Sidney W. Lowery M.D.

Address: 601 - Wash. Blvd. District Heights, Md. M.D. or other

Date signed 1-20-48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

938 00732 245

Reg. Dist. No. ~~[illegible]~~

1. PLACE OF DEATH:
County: Prince George
City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Takoma Park.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7006 - Woodland ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs Ada Julia Blackburn

3.(b) Social Security Number

4. Sex: F
5. Color or race: C
6.(a) Single, married, widowed, or divorced: W.
6.(b) Name of husband ~~or wife~~: George M. Blackburn
7. Birth date of deceased (mo., day, yr.): June 25 1873
6.(c) If alive, give age ... years

8. AGE: Years: 74 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: None
11. Industry or business: —

FATHER
12. Name: James Burgess
13. Birthplace: —

MOTHER
14. Maiden name: —
15. Birthplace: —

16. Informant: George Blackburn
Address: 7006 Woodland Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 20 1948 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.
18. Funeral director: Robert F. McGuire
Address: 1820 - 9 St. N.W.
19. Jan 16 1948 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16 1948 at 12:30 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1947 to Jan 16 1948 and that I last saw her alive on Jan 16 1948
Immediate cause of death: Acute Cardiac Failure — DURATION
Due to: Arteriosclerotic Heart Disease
Due to:
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dean H. Harding MD, M. D. or other
Address: 113 Carroll St NW Wash DC
Date signed: 1-16-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940a

00733

Reg. Dist. No.

1. PLACE OF DEATH:

County: Pro Geo Co

City or town: Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pro Geo Co

City or town: Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6001 Baltimore Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Emanuel Bowers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	white.	widowed.

6.(b) Name of husband or wife: Mary E. Bowers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 15 - 1860

8. AGE:

Years	Months	Days	If less than one day
87			..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Fire Patrolman

11. Industry or business: Balto. City

FATHER

12. Name: Sabastian Bowers

13. Birthplace: Germany

MOTHER

14. Maiden name: Susan Heisel

15. Birthplace: Md.

18. Informant: Charles C Bowers

Address: 6001 Balto. Ave. Riverdale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 20. 1948 (month) (day) (year)

Cemetery or crematory: Glen Park Cemetery

Location: Smallwood Md

18. Funeral director: F Gaseti sons

Address: Hyattsville Md.

19. Jan. 19. 1948 Mrs. Jas. Severe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18. 1948 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1944 to Jan 18 1948 and that I last saw him alive on Jan 18. 1948

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: [illegible] M.D. M. D. or other

Address: Hyattsville Md Date signed 1-1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. One correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00734

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CB

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23 V

1. PLACE OF DEATH:
County: Prince George's
City or town: Fort Foote
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred:
In a field near Fort Foot
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Conn. County:
City or town: Wilton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Millstone Road RFD#1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME
Lynn Brandt

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith Dare Brandt
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): September 28, 1907

8. AGE: Years: 40 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Lynn, Mass. (Town, county, and state)
10. Usual occupation: Accountant
11. Industry or business

FATHER
12. Name: Ernest C. Bloomquist
13. Birthplace: U. S. A.

MOTHER
14. Maiden name: Florence Lindgren
15. Birthplace: Moline, Ill.

16. Informant: Edith Dare Brandt
Address: Wilton, Conn.

17. Cremation (~~Burial~~, cremation, or ~~removal~~. Which?) Date thereof: Jan 16, 1948 (month) (day) (year)
Cemetery or ~~crematory~~: Lorncliff Crematory
Location: Ardsley N. Y.
18. Funeral director: F. Gaschi sons
Address: Hyattsville Md.

19. 1/14 1948 (Date rec'd by registrar) Amanda Downey Mrs. Alton Davis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 1948 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Crushed chest	
Compound fracture of the skull	
Due to:	
Other conditions: Universal second and third degree burns of the body	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 1/13/48
Where did Injury occur? Fort Foote (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?): In a field near Ft. F
Means of Injury: In an airplane crash Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other
Address: Forestville, Md. Date signed: 1/14/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

183 JB 00735

Reg. Dist. No. 234

1. PLACE OF DEATH:

County: Prince George's

City or town: Fort Washington (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, institution, or street address where death occurred: Potomac River

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Virginia County:

City or town: Alexandria (If outside city or town limits, write RURAL and give nearest town)

Street No.: 608 Gibbons Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ernest Makel Brown

3.(b) Social Security Number:

4. Sex: male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 1900

8. AGE: Years: 47 Months: Days: If less than one day: hrs. min.

9. Birthplace: Alexandria, Va (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Construction

FATHER 12. Name: Henry Brown

13. Birthplace: Virginia

MOTHER 14. Maiden name: Eva Quarty

15. Birthplace: Virginia

16. Informant: Mrs Lillian Jones

Address: 608 Gibbons Street Alexandria Va

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 13 1948 (month) (day) (year)

Cemetery or crematory: Rhine Funeral Home

Location: Alexandria Va.

18. Funeral director: E. Darsch's Sons.

Address: 4739 Baltimore Ave. Hyatts., Md.

19. 1/13 1948 (Date rec'd by registrar) Amanda Downey Registrar

Mrs Alton Davis

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 1948 19 0'Clock A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
asphyxia	
Due to: Drowning	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: undetermined Date of: 12-1-47

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Negative medical Examiner

23. SIGNATURE: [illegible] M. D. or other

Address: Forestville Md. Date signed: 1-12-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The street address is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00736

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: Mitchelville - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two months

Hospital, institution, or street address where death occurred: No

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: — County: —

City or town: 1760 Church Street N.W.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Washington - D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Rose · Burgdorf

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Unknown 1870

8. AGE: Years: 78 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: ~~Washington, D.C.~~ (Town, county, and state)

10. Usual occupation: Dress Maker

11. Industry or business: Same

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs Charles Burgdorf

Address: Mitchelville Md

17. Burial (Burial, cremation, or removal) Which?) Date thereof: JAN 5 1948 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland, Md

18. Funeral director: J. William Lee Sons Co.

Address: 3004 4th St NE Washington DC

19. 1/3 1948 (Date rec'd by registrar) Amanda Browne Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2 1948 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 1947 to Jan. 2 1948 and that I last saw him alive on Jan 1 1947

	DURATION
Immediate cause of death: Bronchial Pneumonia	10 days
Due to: Secondary anemia	3 months
Due to:	
Other conditions: Mitral Stenosis and Cardiac Decompensation	6 months

(include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.: —

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James E. Sarscer M.D. or other

Address: Upper Marlboro, Md Date signed: 1-2-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

00737

Reg. Dist. No. 231

1. PLACE OF DEATH

County: Pr. George

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ days

Hospital, institution, or street address where death occurred: Pr. Geo. Gen'l. Hosp.

How long in hospital or institution? 1½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pr. Geo.

City or town: Bladensburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5203 Annapolis Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Butcher, Charles E.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	m

6.(b) Name of husband or wife: Hattie C. Fry

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 16 - 1867

8. AGE: Years: 80 Months: 9 Days: 14 If less than one day ..... hrs. ..... min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Furniture designer

11. Industry or business: Owner

FATHER 12. Name: Wm. H. Butcher

13. Birthplace: Gallia Co. Ohio

MOTHER 14. Maiden name: Lavina Jones Bu

15. Birthplace: Gallia Co Ohio.

16. Informant: Ethel R. Krueger, daughter

Address: Indianapolis, Indiana

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 2 1948 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland, Md.

18. Funeral director: J. Daniel's Sons

Address: Hyattsville Md.

19. 1/31 1948 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-30 1948 at 12 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-28 1948 to 1-30 1948 and that I last saw him alive on 1-29 1948

Immediate cause of death	DURATION
Acute Hepatitis	5 days
Due to: Acute Suppurative Cholecystitis	?
Due to: Chronic Suppurative Cholecystitis with Lithiasis	?
Other conditions: Cardio-Vascular Renal Disease (Arteriosclerosis)	?

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: Some

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M.D. (M. D. or other)

Address: Int. Rainier Md Date signed 1-30-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00738

13

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Price George

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 4 mos., 27 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 4 mos., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: P.G.

City or town: Bowie
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MARY J. BUTLER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: James Butler

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): November 5, 1908

8. AGE: Years	Months	Days	If less than one day
39	2	26	hrs. min.

9. Birthplace: Prince George, Maryland (Town, county, and state)

10. Usual occupation: Ward Maid

11. Industry or business: - - -

FATHER
12. Name: Sylnester Newman
13. Birthplace: Prince George, Maryland

MOTHER
14. Maiden name: Joana Proctor
15. Birthplace: Prince George, Maryland

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 4, 1948 (month) (day) (year)

Cemetery or crematory: Ascension Church

Location: Bowie, Md.

18. Funeral director: Clarence Doracre

Address: Mitchellville Md

19. Jan. 31, 1948 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 31 1948 at 10 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 3 1946 to JAN. 31 1948 and that I last saw her alive on JAN. 31 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 3 yr. 2 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 1-31-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

Evidence for the change of date of birth and age is shown on G 114 2/19/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

460

00739

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH: 4034 - 34th St.

County

City or town Mt. Rainier, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4034 - 34th St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Michael J. Cain

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, ~~1862~~ 1882

8. AGE: Years	Months	Days	If less than one day
65 ~~85~~	8	27	hrs. min.

9. Birthplace Franconia, Virginia
(Town, county, and state)

10. Usual occupation Guard

11. Industry or business

FATHER 12. Name Corneilus J. Cain

13. Birthplace Brandy, Virginia

MOTHER 14. Maiden name Margaret Shane

15. Birthplace Brandy, Virginia

16. Informant Margaret T. Cain

Address 4034 - 34th St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 26 1948 (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Washington, D.C.

18. Funeral director Wm. J. Malley

Address 3200 - Rhode Is. Ave., Mt. Rainier, Md.

Jan 24 1948 James Berry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1948, at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1948, to Jan 22 1948, and that I last saw him alive on Jan 22 1948.

Immediate cause of death Carcinoma of Rectum and Bladder — DURATION 2 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel J. Sugar M.D.
M. D. or other

Address Mt. Rainier, Md. Date signed Jan 23, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 00740

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: N. Brentwood, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: N. Brentwood, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4514 Rhode Island Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Thomas Kelly Carter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Married

6.(b) Name of ~~husband~~ or wife: Lucy Carter

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE:

Years	Months	Days	If less than one day
53	—	—	hrs. min.

9. Birthplace: Virginia The Plains (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER

12. Name: unknown

13. Birthplace: " "

MOTHER

14. Maiden name: unknown

15. Birthplace: "

16. Informant: Lucy Carter (wife)

Address: 4514 R.I. Ave, N. Brentwood

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 7, 1948 (month) (day) (year)

Cemetery or crematory

Location: Washington, D.C.

18. Funeral director: W. Ernest Lamb Co.

Address: 1432 Pa. Ave. N.W.

19. Jan 7 1948 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7 1948 at 7.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-30 1947 to 1-7-1948 and that I last saw him alive on 1-6-1948

Immediate cause of death: Myocarditis — DURATION: 1 yr.

Due to: Work & Exposure

Due to:

Other conditions: Arthritis

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. H. Spiller M.D. M. D. or other

Address: Brentwood, Md. Date signed: 1-9-48

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Over

00741

1952

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Chapel Oaks
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, Institution, or street address where death occurred: 1101 - 57th Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Chapel Oaks
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1101 - 57th Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Sharon Ann Cash

3. (b) Social Security Number

4. Sex: Female
5. Color or race: Negro
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan-48

8. AGE: Years | Months | Days: 6 | If less than one day: 6 hrs. min.

9. Birthplace: Chapel Oaks, Md.
(Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Seaton Daniel Cash
13. Birthplace: Cedar Heights, Md.
MOTHER 14. Maiden name: Mary Katherine Brown
15. Birthplace: Washington, D.C.
16. Informant: Parents
Address: Same
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/19/48 (month) (day) (year)
Cemetery or crematory: Home
Location: 1101 57th Pl. Chapel Oaks
18. Funeral director: Seaton D. Cash
Address: 1101 57th Pl. Chapel Oaks
19. Jan. 19 1948 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18 1948 at 7:A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Birth 1/2 1948 to Jan. 18 1948
and that I last saw her alive on Jan. 18 1948

Immediate cause of death	DURATION
Drowned by Aspiration	
Due to: Regurgitation of Milk	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A. Robinson, M.D. M.D., or other
Address: 1601 Eastern Ave. NE Date signed: 1/18/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1/19/48 – 12:30 P.M.

Dr. Boyd has been consulted about this death and gives his OK for the certificate.

John L. Robinson, M.D.

Evidence for the change of year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

FILM No. G 114 FEB 20 1948

Reg. Dist. No. 239

00742

1. PLACE OF DEATH:

County: Prince Geo

City or town: Laurel R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Pr Geo

City or town: Laurel R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Walter Crockett

3. (b) Social Security Number

4. Sex: M

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary Catherine Crockett

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 17 – 1872 1876

8. AGE: Years 71 Months 10 Days 27 If less than one day hrs. min.

9. Birthplace: Howard Co. Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER
12. Name: David Crockett
13. Birthplace: Howard Co Md.

MOTHER
14. Maiden name: Mary Chambers
15. Birthplace: Howard Co. Md

16. Informant: William H. Elgar
Address: Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 26/48 (month) (day) (year)

Cemetery or crematory: Lyons Hill Laurel Md

Location: Laurel Md

18. Funeral director: The H. C. White Co Inc

Address: Laurel Md

19. 1-26 1948 Cora C. Wachter Deputy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22 1948 at 12:27 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1948 to January 22 1948 and that I last saw him alive on January 21 1948

Immediate cause of death: Cerebral hemorrhage
Left Sided hemiplegia — DURATION 1 week

Due to: Hypertensive Cardio-Vascular Disease — approx 10 yrs

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Stephens M.D. M. D. or other

Address: Laurel, Md. Date signed 1/26/48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

188

00743

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Prince George General Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Mitchellville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Patricia Crouch

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1940

8. AGE: Years 7 Months 8 Days 17 If less than one day hrs. min.

9. Birthplace District of Columbia (Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER 12. Name Leroy Crouch

13. Birthplace Washington, D.C.

MOTHER 14. Maiden name Dorothy L. Miller

15. Birthplace Washington, D.C.

16. Informant Hospital records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-25-48 (month) (day) (year)

Cemetery or crematory

Location Washington, D.C.

18. Funeral director J. Wm. Lee Sons Co.

Address 300-4 St. N.E.

19. Jan 25 1948 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1948 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death: Surgical shock — Duration: 4 hrs

Due to: Cremation — 3 hrs

Due to: Brain scar — 1 month

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 12-17-47

Where did injury occur? Mitchellville (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Farm

Means of injury? Hitched to a horse Injured at work?

Deputy Medical Examiner

23. SIGNATURE M.D., or other

Address Forestville Md. Date signed 1-24-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00744

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 745

1. PLACE OF DEATH:
County: Co. Geo. G
City or town: College Park md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Co. Geo. G
City or town: College Pk md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4801 - Calvert Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Katie V. Darcy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Alonza Darcy
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Jan 8 - 1875

8. AGE: Years: 73 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Crosiere, md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Noah Frye
13. Birthplace: md
MOTHER 14. Maiden name: Lucy V. Fowler
15. Birthplace: md
16. Informant: Mrs Gustavia V. Ryan
Address: 4801 - Calvert Rd. College Pk md
17. Buried (Burial, cremation, or removal. Which?) Date thereof 1/30-48 (month) (day) (year)
Cemetery or crematory: Forestville
Location: Maryland
18. Funeral director: W W Chambers Co
Address: Riverdale - md
19. Jan 30 1948 (Date rec'd by registrar) Mrs Jos Devere Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-28 1948 at 7 55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 28 1948 to January 28 1948 and that I last saw her alive on January 28 1948

Immediate cause of death: Chronic Myocarditis — DURATION: Several years
Due to: Senility — DURATION: Several years
Due to: — DURATION:
Other conditions: — DURATION:
(Include pregnancy within 3 months of death)
Major findings of operations: — Date of op. —
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: W. Allen Griffith M. D. or other
Address: Berwyn Md Date signed 1/29/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ing correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 1a

Reg. Dist. No. 00745 232

1. PLACE OF DEATH:

County: Pr. Geo

City or town: Upper Marlboro Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Pr. Geo.

City or town: Rural - Upper Marlboro Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mills Bridge
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Henrietta West Ulent

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	widowed

6.(b) Name of husband or wife: Henry A. Ulent.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 16 1884

8. AGE:

Years	Months	Days	If less than one day
63	10	10	..... hrs. ..... min.

9. Birthplace: Pr. Geo Co Md
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Clem West
13. Birthplace: Upper Marlboro, Md

MOTHER
14. Maiden name: Catherine Langer
15. Birthplace: Pr. Geo. Co

16. Informant: Regina Pruss

Address: 1423 Myrtle Ave. Balt. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 29 1948 (month) (day) (year)

Cemetery or crematory: Arbutus

Location: Baltimore, Md

18. Funeral director: J. B. Johnson

Address: Annapolis

19. Jan 29 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 Jan 1948 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to 26 Jan 1948 and that I last saw h.. er alive on 21 Jan 1948. 19..

Immediate cause of death	DURATION
Uremia	3 days
Due to: Chronic nephritis	Unk
Due to: Arteriosclerotic Cardiovascular Renal Disease	Unk
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert B Sawyer M. D. ~~or other~~

Address: Upper Marlboro, Md. Date signed 26 Jan 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00746

50

Reg. Dist. No. 245

1. PLACE OF DEATH: 3400 Bunker Hill Rd
County: PRINCE GEORGES
City or town: Mt. Rainier, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3400 Bunker Hill Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
AMANDA S. DETWILER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOWED

6.(b) Name of husband or wife: William E Detwiler
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): June 22 1882

8. AGE:

Years	Months	Days	If less than one day
65	6	15	____ hrs. ____ min.

9. Birthplace: Philadelphia, Penna
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER
12. Name: Adam Kreppel
13. Birthplace: Germany
MOTHER
14. Maiden name: Susan Scher
15. Birthplace: Germany
16. Informant: (daughter) Irene Travascio
Address: 3400 Bunker Hill Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 9 1948 (month) (day) (year)
Cemetery or crematory: Northwood Cemetery
Location: Philadelphia, Pa.
18. Funeral director: Wm. J. Nalley
Address: 3200 - R.I. Ave. Mt. Rainier, Md.
19. Jan 8 1948 James Seray
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 6 1948 at 3 PM
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1947 to Jan 1948
and that I last saw her alive on Jan 4 1948

Immediate cause of death	DURATION
Hypostatic Pneumonia	3 days
Due to: Carcinomatosis Thorax, abdominal	4 years
Due to: Carcinoma (Inoperable) of Rt. Breast	5 years
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Benjamin S. Miller M.D.
M. D. or other
Address: 3824 - 34 St. Date signed: Jan 6 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00747

122b

Reg. Diat. No. 231

1. PLACE OF DEATH:

County: Prince George's

City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day 19 hours 20 minutes

Hospital, Institution, or street address where death occurred:
Prince George's General

How long in hospital or institution? 1 day 19 hrs. 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4207 32nd Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Marie Dobberfuhl

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 4, 1945

8. AGE: Years	Months	Days	If less than one day
2	1	21	hrs. min.

9. Birthplace: District of Columbia
(Town, county, and state)

10. Usual occupation: child

11. Industry or business

FATHER
12. Name: Rudolph W. Dobberfuhl
13. Birthplace: Detroit, Michigan

MOTHER
14. Maiden name: Marie Elizabeth Moentmann
15. Birthplace: St. Charles, Missouri

16. Informant: Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 27, 1948 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Bladensburg Rd. - D.C. line

18. Funeral director: William J. Nalley

Address: 3200 Rhode Is.Ave., Mt.Rainier, Md.

19. Jan 27 1948 (Date rec'd by registrar) ~~James Seray~~ Amanda [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25, 1948 19 at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 22 1948 to Jan 25 1948 and that I last saw him alive on Jan 24 1948

	DURATION
Immediate cause of death: INANITION with Intestinal obstruction due to	1 week
Due to: Failure of ROTATION of the caecum with volvulus	Congenital
Due to: of the small intestine at the ligamen of TREITZ	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Benjamin S. Miller M. D. or other

Address: 3824-34th St Rainier Date signed: Jan 25 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00748

1310

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George's
City or town: Croome
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George'S
City or town: Croome
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Jaes A. Doherty

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) August 26, 1898

8. AGE: Years 49 | Months | Days | If less than one day hrs. min.

9. Birthplace Savanah, Georgia
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Charles Dbherty
13. Birthplace Canada
MOTHER 14. Maiden name Sarah Knox
15. Birthplace Canada
16. Informant Mrs. Henry Beranc
Address 1318 E. Henry Street, Savanah, Ga.
17. transportation Date thereof Jan 9, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory savanah
Location Georgia
18. Funeral director F Gosche Sons
Address Wyattsville Md
19. Jan. 9 1948 Amanda Doueng
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1948 at 9:00PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions: Acute alcoholism	

(Include pregnancy within 3 months of death)
Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
Deputy Medical Examiner
23. SIGNATURE James F. Ford M.D. Coroner
Address Forestville, Md. Date signed 1/9/48

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107 00749

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prs Geo Co

City or town: Hyattsville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Prs Geo Co

City or town: Hyattsville Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 43 Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Amanda Ludrow

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: otis Ludrow

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 4, 1870.

8. AGE: Years 77 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: west va (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: John Burch

13. Birthplace: unknown

MOTHER 14. Maiden name: sallie smith

15. Birthplace: unknown

16. Informant: Mrs otis Ludrow

Address: Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 2. 1948 (month) (day) (year)

Cemetery or crematory: Hyattstown Cemetery

Location: Hyattstown Md

18. Funeral director: F Busche sons

Address: Hyattsville Md.

19. Feb 1 1948 James Levey (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 30, 1948, at 2a M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to 1-30 1948 and that I last saw him alive on 1-29 1948

Immediate cause of death: Pneumonia

bronchial [2/19/48-abc]

DURATION: 3 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Jerome Levey M. D. or other

Address: Hyatts Md Date signed 1-31-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

958

00750

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH:

County: Prince George's

City or town: Clinton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, Institution, or street address where death occurred: Old Alexander Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Clinton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Old Alexander Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Hume Dailey

3.(b) Social Security Number: 577-28-0208

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elvira J. Dailey

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): November 5, 1911

8. AGE: Years: 36 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Guard

11. Industry or business: U.S. Post

FATHER

12. Name: Jake E. Dailey

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mary E. Ellis

15. Birthplace: Virginia

16. Informant: Ellis Lane Dailey

Address: Upper Marlboro, Md.

17. Burial (Burial, cremation, or removal?) Date thereof: 1-29-48 (month) (day) (year)

Cemetery or crematory: Christ Church

Location: Clinton, Md.

18. Funeral director: Pitts Brothers

Address: Upper Marlboro, Md.

19. Jan 28 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 27 1948 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...

and that I last saw h... alive on ..... 19...

Immediate cause of death: Acute Congestive heart failure

Due to: Rheumatic heart disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other

Address: Forestville Md. Date signed: 1-27-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 00751 232

Reg. Dist. No.

1. PLACE OF DEATH:

County: Pr. Geo.

City or town: Rural - Upper Marlboro Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Pr. Geo.

City or town: Rural - Upper Marlboro, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 miles north
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Nettie Elvert Duley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 10 1883

8. AGE: Years	Months	Days	If less than one day
64	4	20	hrs. min.

9. Birthplace: Croom, Pr. Geo Co. Md (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: U.S. Government

MOTHER FATHER

12. Name: Norval Edward Duley

13. Birthplace: Croom, Md

14. Maiden name: Mary Annette Taylor

15. Birthplace: Croom, Md

16. Informant: Bernard Reginald Duley

Address: ~~Upper Marlboro~~ Mitchellsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 2 - 48. (month) (day) (year)

Cemetery or crematory: St. Thomas

Location: Croom, Md.

18. Funeral director: Wilcoxen Brothers

Address: Upper Marlboro, Md.

19. Feb 2 1948 Edward Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 Jan 1948 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 Jan 1948 to 30 Jan 1948 and that I last saw him alive on 29 Jan 1948

Immediate cause of death: Coronary Thrombosis — DURATION: 10 min.

Due to: Arteriosclerotic C.V. Disease — Unk.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Robert B. Lanier M. D.

Address: Upper Marlboro, Md. Date signed: 30 Jan 48

12 48 I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 00753

Reg. Dist. No. 245

1. PLACE OF DEATH: County: Prince Geo. City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, Institution, or street address where death occurred: Mother Joan Nursing Home. How long in hospital or institution? 4 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State: Md. County: Prince Geo. City or town: Mt Rainier (If outside city or town limits, write RURAL and give nearest town) Street No. 4203 - 28th St. (If rural, give LOCATION) 2.(a) If veteran, name war:

3. (a) FULL NAME Catherine E Eddy

3. (b) Social Security Number

4. Sex: Fem. 5. Color or race: White. 6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 10 1868

8. AGE: Years 79 Months 2 Days — If less than one day: hrs. min.

9. Birthplace: Wash D.C. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Thomas H. Eddy 13. Birthplace: Maryland

MOTHER 14. Maiden name: Frances Connor 15. Birthplace: Wash. D.C.

16. Informant: Samuel Fort Address: 4203 - 28th St. Mt Rainier

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/13/48 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Location: Bladensburg Rd & D.C. line

18. Funeral director: W. E. Nalley Address: 3200 - R.I. Ave Mt Rainier

Jan 13 1948 (Date rec'd by registrar) James Leroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/10/1948 at 5 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/21/1947 to 1/10/1948 and that I last saw her alive on 1/7/1948

Immediate cause of death: Cardiovascular Arteriosclerosis — DURATION: 1 8 Months

Due to: Cause: —

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howard T. Moore M.D. M. D. or other

Address: 28 Carroll Ave. Takoma Park Md. Date signed: 1/10/48

VS A15 MARGIN RESERVED FOR BINDING I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00752

164c

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 345

1. PLACE OF DEATH:

County: Prince Georges

City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred: Rosemary Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town)

Street No.: Rosemary Lane (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Gilbert Eckles

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Jane Figg Eckles

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): August 15, 1899

8. AGE: Years 48 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Sardis, Miss. (Town, county, and state)

10. Usual occupation: Teacher (Professor of Education)

11. Industry or business: University of Maryland

FATHER 12. Name: John Brooks Eckles

FATHER 13. Birthplace: Mississippi

MOTHER 14. Maiden name: Corrine Pepper

MOTHER 15. Birthplace: Pepington, Miss.

16. Informant: Mrs. Jane F. Eckles

Address: Rosemary Lane, Hyattsville, Md.

17. Transportation Date thereof: Jan. 28, 1948 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory: Sardis

Location: Mississippi

18. Funeral director: F. Gasch's Sons

Address: Hyattsville Md.

19. Jan 29 1948 James Berry (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1948 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death: Hemorrhage and shock — DURATION

Due to: Gun-shot wound of head

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 1-27-48

Where did injury occur? Hyattsville (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Shot self with a 38 Colt A.A. Wrecker

Respectfully medical Examiner

23. SIGNATURE James J. Bond M. D. or other

Address: Forestville, Md. Date signed: 1-28-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be certain the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

00754

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: PRINCE GEORGE.

City or town: FAIRMONT Hgts.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 YRS.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Fairmont Hgts.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5711 - Jost St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ann Smith Edwards.

3. (b) Social Security Number

None.

4. Sex: F.

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: WIDOW

6.(b) Name of husband or wife: Wm. EDWARDS (DEC)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): MAY 12, 1852

8. AGE: Years: 95 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: RICHMOND, VA.

(Town, county, and state)

10. Usual occupation: NONE

11. Indusfry or business: —

FATHER

12. Name: ROBERT SMITH

13. Birthplace: VA.

MOTHER

14. Maiden name: HARRIETT PRICE

15. Birthplace: VA.

16. Informant: MRS. ANNIE E. KING

Address: 5711 JOST ST., N.E.

17. ..... Date thereof ..... (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director: Robert G. McGuire

Address: 1820 - 9th St., N.W.

19. Jan 11 1948 Carrie J. Campbell

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 1948 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 7 1948, to January 10 1948 and that I last saw h. alive on January 10 1948

Immediate cause of death: Cerebral Accident

Due to: Essential Hypertension

Due to: 1

Other conditions: Nephrosclerosis

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: 4832 Bennett Place NE Wash 19, D.C. Date signed: 1-10-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1572

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a 00755

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred: 5875 Addison Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5875 Addison Road

(If rural, give LOCATION)

2.(a) If veteran, name war: WORLD WAR I

3.(a) FULL NAME: Bernard Robert Edwards Sr

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary Edwards

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 19, 1896

8. AGE: Years: 51 Months: Days: If less than one day: hrs. min.

9. Birthplace: Washington DC (Town, county, and state)

10. Usual occupation: Real Estate

11. Industry or business:

FATHER 12. Name: James Edwards

FATHER 13. Birthplace: Washington DC

MOTHER 14. Maiden name: Mary Leonard

MOTHER 15. Birthplace: Washington DC

16. Informant: Mrs Mary Edwards

Address: 5875 Addison Rd, Seat Pleasant Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-14-48 (month) (day) (year)

Cemetery or crematory: Ft Lincoln

Location: Washington DC

18. Funeral director: Francis J. Collins

Address: 3821-14th St. N.W. Wash. DC

19. Jan. 11 1948 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11, 1948, at 3 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death: Acute Congestive heart failure

Due to: Cardiovascular renal disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other

Address: Freshfield Md Date signed 1-11-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00755

131 b

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Pr. George's
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, Institution, or street address where death occurred: Pr. Geo. Gen'l.
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4308 Hamilton St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Espey, M. William

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept. 18 - 1869

8. AGE: Years 78 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: D.C.
(Town, county, and state)
10. Usual occupation: Salesman - retired
11. Industry or business

FATHER
12. Name: Frank H. Espey
13. Birthplace: D.C.

MOTHER
14. Maiden name: Mina Mitchell
15. Birthplace: D.C.

16. Informant: Miss Agnes L. Espey
Address: 4308 Hamilton St. Hyattsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 15 1948 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Washington D.C.
18. Funeral director: F. Gaschy Sons
Address: Hyattsville Md.

19. 1/16 1948 (Date rec'd by registrar) Amanda Devine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-12 1948 at 6 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1, 1945 to Dec 12 1948 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Pulmonary emphysema with Chronic Bronchitis	
Due to: Pulmonary atrophy	
Due to: Chronic glomerulonephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Hyattsville Md. Date signed: 1-12-49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

06757

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 24 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or Institution? 2 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 417 E. Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME LAURA FRAZIER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Charles Frazier (deceased)

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23, 1885

8. AGE: Years	Months	Days	If less than one day
62	8	19	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Days Work

11. Industry or business: - - -

FATHER
12. Name: Robert Payne
13. Birthplace: ? ?

MOTHER
14. Maiden name: Mary Howard
15. Birthplace: ? Virginia

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1/12/48 (month) (day) (year)

Cemetery or crematory

Location: Washington D. C.

18. Funeral director: A. Ernest Jarvis Co
Address: 1432 Gri St. N.W. Wash. D.C.

19. Jan. 12, 1948 (Date rec'd by registrar) Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11th 1948 at 4 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 17th 1947 to January 11 1948 and that I last saw him alive on January 11th 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs
Due to: Diabetes Mellitus	6 mo
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)

Address: Glenn Dale, Md. Date signed 1/11/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00758

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 1038 - 16th St., N. E. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: ZOLA GLOVER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: - - -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 16, 1911

8. AGE: Years	Months	Days	If less than one day
36	8	19	..... hrs. ..... min.

9. Birthplace: Curvin, Georgia (Town, county, and state)

10. Usual occupation: - - -

11. Industry or business: - - -

FATHER 12. Name: Edward Glover

13. Birthplace: ? Georgia

MOTHER 14. Maiden name: Ludie Heard

15. Birthplace: ? Georgia

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 1/6/47 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: John H. Stewart Jr.

Address: #30 "H" St. N.E. Wash., D.C.

19. Jan. 6, 1948 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 4, 1948 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 30, 1947, to Jan. 4, 1948 and that I last saw h. er alive on Jan. 3, 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 7 mo.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: 1/4/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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00759

47c

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:

County: Prince George

City or town: Baden, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Baden (If outside city or town limits, write RURAL and give nearest town)

Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: Mamie H. Grant

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: James S. Grant

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Nov. 7-1881.

8. AGE: Years 66 Months 2 Days 8 If less than one day ... hrs. ... min.

9. Birthplace: Baden, Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER 12. Name: James Hyde

13. Birthplace: Baden, Maryland

MOTHER 14. Maiden name: Anna Hyde

15. Birthplace: Baden, Maryland

18. Informant: Porter Hyde (Burke)

Address: Baden, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-17-48. (month) (day) (year)

Cemetery or crematory: St. Paul's

Location: Baden, Md.

18. Funeral director: Pilkne Bros.

Address: Upper Marlboro, Md.

19. Jan. 16 1948 (Date rec'd by registrar) F. H. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 15 1948 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb — 1947 to Jan 15 1948 and that I last saw h. Ex. alive on Jan 9 1947

Immediate cause of death: Vascular Collapse

Due to: probably internal hemorrhage

Due to: Bronchogenic Carcinoma

Other conditions: Diffuse Carcinoma

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Alfred R. Lapin, M.D. M. D. or other

Address: Cheverly, Md. Date signed: Jan 15, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00760

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 6 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6503 Sharon Drive, Silver Spring, MD.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: JOHN ROLAND GRIGGS

3. (b) Social Security Number: 579-07-0369

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Evelyn Griggs

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): July 2, 1903

8. AGE: Years	Months	Days	If less than one day
44	6	20	hrs. min.

9. Birthplace: Charles County, Maryland
(Town, county, and state)

10. Usual occupation: Policeman

11. Industry or business: - - -

FATHER
12. Name: Charles W. Griggs
13. Birthplace: St. Mary's County, Maryland

MOTHER
14. Maiden name: Ada Dows
15. Birthplace: England

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 22, 1948 (month) (day) (year)

Cemetery or crematory

Location: Silver Spring, Md

18. Funeral director: Warner E. Humphrey

Address: Silver Spring, Md

19. Jan. 22, 1948 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 22 1948 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15, 1947, to Jan. 22, 1948 and that I last saw him alive on Jan. 21, 1948.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr 9 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Daniel Leo Finnegan M.D.

Address: Glenn Dale, Md. Date signed: 1/22/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

00761

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Prince Georges General

How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DEECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Landover

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Central Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sylvia Hasshaw

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Richard Hasshaw

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 5, 1884

8. AGE: Years	Months	Days	If less than one day
63	1	8	..... hrs. ..... min.

9. Birthplace: Wisconsin (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: William Egbert Hasshaw

13. Birthplace: Unknown

MOTHER — 14. Maiden name: "

15. Birthplace: "

16. Informant: Richard Hasshaw

Address: Landover, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-13-48 (month) (day) (year)

Cemetery or crematory: W W Chambers Co

Location: 577-11 St SE

18. Funeral director: W W Chambers Co

Address: 577-11 St SE Wash DC

19. 1/13 1948 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1948 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death: Intra cranial hemorrhage

Due to: Cardiovascular renal disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results: autopsied

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Deputy medical Examiner

23. SIGNATURE: [illegible] M. D. or other

Address: Greenbelt Md Date signed 1-13-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00762

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
Leland Memorial Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Pro. Geo.

City or town: Ardmore
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mr. McClellan Henderson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife: Sadie Roberts.
deceased

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 17. 1884

8. AGE: Years	Months	Days	If less than one day
64	10	29	____ hrs. ____ min.

9. Birthplace: north Carolina
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER
12. Name: Len Henderson
13. Birthplace: north Carolina

MOTHER
14. Maiden name: Hester ?
15. Birthplace: north Carolina

16. Informant: Hospital records.

Address

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Jan 20 1948 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland Maryland

18. Funeral director: F. Gaschi Sons

Address: Hyattsville Md.

Jan 19 1948 James Seay
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 17 1948, at 3 45 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1948, to Jan 17 1948 and that I last saw him alive on Jan 17, 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 2 yrs ?

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L A Mealin MD
M. D. or other

Address: Riverdale, Md Date signed: 1-19-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure to give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00763

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years, 10 months, 1 day

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 5 years, 10 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 420 11th St., S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME ALICE HOVERMILL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frederick Hovermill

6.(c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.): March 24, 1864

8. AGE: Years	Months	Days	If less than one day
83	9	29	hrs. min.

9. Birthplace: Berkley Springs, West Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -

FATHER
12. Name: Henry Fearnow
13. Birthplace: ? West Virginia

MOTHER
14. Maiden name: Mary Jane Bohrer
15. Birthplace: ? West Virginia

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 23, 1948 (month) (day) (year)

Cemetery or crematory

Location: Berkley Springs, West Virginia

18. Funeral director: F. Gasch's Sons

Address: Hyattsville, Md.

19. Jan. 23 1948 (Date rec'd by registrar) Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 22 1948 at 6:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAR. 23, 1942 to JAN. 22 1948 and that I last saw h. alive on JAN. 22 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 6 yr.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: 1-22-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Insert correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00764

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Prince Georges General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Ritchie (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1979 Walker Mill Road (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Gertrude Margaret Hunt

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Richard Hunt

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Sept 17, 1887

8. AGE: Years: 60 Months: Days: If less than one day: hrs. min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Ireland

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Ireland

16. Informant: John J. Hunt

Address: 1725 - Bryant St. Forestville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/19/48 (month) (day) (year)

Cemetery or crematory: Washington National

Location: Suitland Rd. Md.

18. Funeral director: W. H. Chambers Co

Address: 517-11th St. Wash. DC

19. 1/16 1948 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 1948 at 1045 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19..... and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Shock and Hemorrhage — DURATION

Due to: Intestinal hemorrhage

Due to:

Other conditions: Bronchopneumonia

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James E. Boyd M. D. or other

Address: Forestville Md. Date signed: 1-16-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13/a

00765

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George's County

City or town: Chevely

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hours

Hospital, institution, or street address where death occurred: Prince George's General Hospital

How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Mount Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4010 33d Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JAMES LEACH HUTCHINSON SR.

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary A. Hutchinson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 7, 1886

8. AGE: Years 61 Months 2 Days 21 If less than one day ..... hrs. ..... min.

9. Birthplace: New Jersey (Town, county, and state)

10. Usual occupation: Stone Setter

11. Industry or business

FATHER 12. Name: Samuel R. Hutchinson

13. Birthplace: England

MOTHER 14. Maiden name: Margaret Hayworth

15. Birthplace: England

16. Informant: Miss. Frances Hutchinson

Address: 4010 33d St., Mt. Rainier, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/31/48 (month) (day) (year)

Cemetery or crematory: Wash. Natl. Cemetery

Location: Suitland Md.

18. Funeral director: W. W. CHAMBERS COMPANY

Address: 5801 Cleveland Ave., Riverdale, Md.

19. 1/30 1948 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1948 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Intra Cranial hemorrhage	
Due to: Hemorrhage in Cerebellum	
Due to: Cardiovascular renal disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy Medical Examiner M. D. or other

Address Forestville Md. Date signed 1-28-48

00766

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 242

1. PLACE OF DEATH:

County: Prince George

City or town: Forestville, Tanham

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Forestville, Tanham Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Julia Elizabeth Jackson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 30, 1947

8. AGE: Years 0 | Months 5 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace Forestville, Tanham Md, (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Frank Alfred Jackson

13. Birthplace Glenn Dale Md

MOTHER 14. Maiden name Ella Sarah Prince

15. Birthplace Seabrook Md

16. Informant Frank A. Jackson

Address Forestville, Tanham Md

17. Burial Date thereof Jan 6 1948 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Brookland Glenn Dale Md

Location Glenn Dale Md

18. Funeral director Frank A. Jackson (Father)

Address Lincoln Upper Marlboro Md

19. Jan 6 1948 Mrs Jack Bennette Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1948 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1947 to Jan 5 1948 and that I last saw him alive on Jan 5 1948

Immediate cause of death: Bronchopneumonia — DURATION: 3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert S. McConey M.D. M.D. or other

Address 402 Main St Laurel Md Date signed 1/5/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. One form for each death is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00767

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1306 - Fourth St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME ROSIE JAMES.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Jessie James (common-law)

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): September 1, 1897

8. AGE: Years	Months	Days	If less than one day
50	4	0	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Government Charwoman

11. Industry or business: - - -

FATHER
12. Name: Samuel Garrett
13. Birthplace: ?

MOTHER
14. Maiden name: Mary Anderson
15. Birthplace: ?

16. Informant: Deceased

Address

17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof 1 3 48 (month) (day) (year)

Cemetery or crematory

Location to Wash. D.C.

18. Funeral director: ITALIAN - SCHEY INC

Address 424 R St N.W - WASH D.C

19. Jan. 3 1948 (Date rec'd by registrar) Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 1 1948 at 1.08 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 31 1947, to Jan 1 1948 and that I last saw him alive on Jan. 1 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 5 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed 1/1/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

00768

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince George

City or town: Seat Pleasant, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Seat Pleasant, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 89 Addison Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Miss Louise Jamison

3.(b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: 80? Months: Days: If less than one day ... hrs. ... min.

9. Birthplace: Virginia (town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: Baker Jamison

13. Birthplace: Washington, D.C.

MOTHER

14. Maiden name: Ella W. Langer

15. Birthplace: Maryland

16. Informant: Robert H. McNeil

Address: Rowen Bldg., Wash. D.C.

17. Transportation Date thereof Jan. 23 '48 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Calvary Cemetery

Location: Long Island City, N.Y.

18. Funeral director: J. S. Jones Co.

Address: 2901 14th St. N.W. Wash. D.C.

19. Jan 17 1948 Amanda Downing (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17, 1948 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 16, 1948 to January 17, 1948 and that I last saw her alive on January 16, 1948

Immediate cause of death: Cerebral disease

Due to: Acute heart failure

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. Agar, M.D. or other

Address: Seat Pleasant, Md. Date signed: January 17, 1948

Downing Bros. Co. 1495

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

00769

164c

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George's
City or town: University Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3½ years
Hospital, Institution, or street address where death occurred:
4312 Clagett Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: University Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4312 Clagett Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
John Gamewell Jenkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Valorie Jenkins
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): May 30, 1901

8. AGE: Years: 46 Months: 8 Days: ____ If less than one day ____ hrs. ____ min.

9. Birthplace: New Jersey (Town, county, and state)
10. Usual occupation: Professor of Psychology
11. Industry or business: University of Maryland

FATHER
12. Name: Edward E. Jenkins
13. Birthplace: Charlestown, S. C.

MOTHER
14. Maiden name: Mary Gamewell
15. Birthplace: Charleston SC.

16. Informant: Valorie Jenkins
Address: University Park, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Feb 3, 1948 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland Md
18. Funeral director: F. Gaschè Sons
Address: Hyattsville Md.

19. Feb 2 (Date rec'd by registrar) 1948 James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30 19 48, at 7:00 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____
and that I last saw h____ alive on ____ 19____

Immediate cause of death: Hemorrhage and shock — DURATION
Due to: Gun shot wound of the chest and abdomen
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 1/30/48
Where did injury occur? University Pk. (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Shot self Injured at work?

23. SIGNATURE: Deputy Medical Examiner James G. Boyd M.D. or other
Address: Forestveille, Md. Date signed: 2/1/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00770

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months, 1 day

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 6 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 649 Keefer Place, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOSEPH JOHNSON, JR.

3.(b) Social Security Number: 577-12-6947

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Juanita Johnson

6.(c) If olive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): September 14, 1908

8. AGE: Years	Months	Days	If less than one day
39	4	9	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Cleaned fish

11. Industry or business: - -

FATHER
12. Name: Joseph Johnson, Sr.,
13. Birthplace: Alexandria, Virginia

MOTHER
14. Maiden name: Fannie Early
15. Birthplace: Washington, D. C.

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-23-48 (month) (day) (year)
to Wash DC

Cemetery or crematory:

Location:

18. Funeral director: W. Ernest Garrison Co.

Address: 1427 Yorkshire St. N.W.

19. Jan 23, 1948 (Date rec'd by registrar) Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 23 1948 at 10 15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 21 1947 to JAN. 23 1948 and that I last saw him alive on JAN. 23 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 9 mo.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)

Address: Glenn Dale Md. Date signed: 1-23-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243 — 00771

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2148 O. St., N. W., Apt. #209
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME
NELLIE WINE JONES

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas G. Jones

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): December 15, 1898

8. AGE: Years	Months	Days	If less than one day
49	1	15	hrs. min.

9. Birthplace: Marshall, Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: - - -

FATHER
12. Name: William Wine
13. Birthplace: Marshall, Virginia

MOTHER
14. Maiden name: Annie Leonard
15. Birthplace: Marshall, Virginia

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/2/48 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery
Prince Georges County
Location: Mary Land

18. Funeral director: The A. H. Thies Co
Address: 3901 14th St N.W.

19. Feb. 2, 1948 (Date rec'd by registrar) Rowland S. Phillips, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 30 1948 at 10 05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11:30 AM. JAN. 30 1948 to JAN. 30 1948 and that I last saw h.e.r. alive on JAN. 30 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION 2 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: 1-31-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00772

61

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George's

City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:
Prince George's General Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Landover
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Harry Linton

3.(b) Social Security Number

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Martha R. Linton

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): May 3, 1868

8. AGE: Years 79 | Months 8 | Days 27 | If less than one day ... hrs. ... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Navy Yard

FATHER
12. Name: Jerome Linton
13. Birthplace: Virginia

MOTHER
14. Maiden name: Laura Arnold
15. Birthplace: Maryland

16. Informant: Hospital Records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 3, 1948 (month) (day) (year)

Cemetery or crematory: Congressional

Location: Washington, D.C.

18. Funeral director: H. M. Chambers Co.

Address: 5801 Cleveland Ave Riverdale, Md

19. 2/2 1948 Rhonda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31 1948 at 7:03 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 29 1948 to January 31 1948 and that I last saw him alive on January 31 1948

	DURATION
Immediate cause of death: Cerebral hemorrhage	2 days
Due to: Hypertension	Unknown
Due to: Arteriosclerosis	Unknown
Other conditions: Diabetes mellitus	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.: None

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of: No

Where did injury occur? No (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): No

Means of injury: No Injured at work? No

23. SIGNATURE: Julius Kauffman M.D.
M. D. or other

Address: 5423 Annapolis Rd. Date signed: 1/31/48
Hyattsville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, be correct and is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 8-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00773

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 13 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 year, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 460 Ridge St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME
NANCY LUCAS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Separated

6.(b) Name of husband or wife: Floyd Lucas

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): December 25, 1899

8. AGE: Years	Months	Days	If less than one day
48	0	5	hrs. min.

9. Birthplace: Wilson County, North Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: - - - - - - -

FATHER
12. Name: Bill Blunt
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Lulu Vicks
15. Birthplace: Wilson, North Carolina

16. Informant: Deceased

Address

17. Removal
(Burial, cremation, or removal. Which?)
Date thereof: JAN. 11 48
(month) (day) (year)

Cemetery or crematory: To Washington, DC

Location

18. Funeral director: H. Ernest Davis Co.

Address: 1432 You St. N.W.

19. Jan. 11 1948 Rowland S. Philips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9 1948 at 6.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 27 1946, to Jan 9 1948 and that I last saw him alive on Jan 9 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION 1½ yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 1/9/48.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write on this page is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00774

938

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Dist. Hgts.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs

Hospital, institution, or street address where death occurred: 211 Wash. Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Geo

City or town: District Hgts. Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 211 Wash. Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME ~~WILLIAM~~ MATHESON, William

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Lillian J. Matheson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 17th 1887

8. AGE: Years 60 Months Days If less than one day hrs. min.

9. Birthplace (Town, county, and state): Sioux City Iowa

10. Usual occupation: Machinac

11. Industry or business: Shop

FATHER 12. Name: John Matheson

13. Birthplace: Unk.

MOTHER 14. Maiden name: Elizabeth Unk.

15. Birthplace: Unk.

16. Informant: Mrs Lillian J. Matheson

Address: 211 Wash. Blvd. Dist. Hgts. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-18-48 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md.

16. Funeral director: W. W. Chambers Co.

Address: 517 11th St S.E.

19. Jan. 10 1948 Carrie F. Campbell Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 10 1948 at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 6 1947 to Jan 9 1948 and that I last saw him alive on Jan 9 1948

Immediate cause of death: Coronary occlusion

Due to: Hypertension (Kent Davis)

Due to:

Other conditions: Arthritis

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Chas. V. Tate M.D. M. D. or other

Address: 335 M St N.E. Date signed 1/10/48

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1958 00775

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George's
City or town: Clinton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mo
Hospital, institution, or street address where death occurred: Waugerfield Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Clinton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Waugerfield Home
(If rural give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jack Ellsworth McAllister

3.(b) Social Security Number

4. Sex: male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Oct 1, 1947
8. AGE: Years | Months: 3 | Days: 26 | If less than one day ... hrs. ... min.
9. Birthplace: Washington, DC
(Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Lawrence McAllister
13. Birthplace: Virginia

MOTHER
14. Maiden name: Laverna Miller
15. Birthplace: Pennsylvania

16. Informant: Mr. Lawrence McAllister
Address: Clinton, Md
17. Burial, cremation, or removal (Which?) Date thereof 1-29-48 (month) (day) (year)
Cemetery or crematory: Mock Hill
Location: Suitland, Md
18. Funeral director: M.W. Blanden's Br
Address: 917-11 St SE
19. Jan. 28 1948 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 27 1948 at 2:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Asphyxiation	
Due to: Aspiration of regurgitated milk	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 1-27-48
Where did Injury occur? Clinton (City or town) (County) (State) Md
Injured at home, farm, industry, public place (where?) Home
Means of Injury Injured at work?
Deputy Medical Examiner
23. SIGNATURE ... M. D. or other
Address: Greenbelt Md Date signed 1-27-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and fully.

VS A15 9-45-15M

170 c 00776

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheltenham (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, Institution, or street address where death occurred: Route 301

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: North Carolina (County)

City or town: Greenville (If outside city or town limits, write RURAL and give nearest town)

Street No. 1303 Evans (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mae Galloway Mobley

3.(b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

8.(b) Name of husband or wife: John R. Mobley

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 30, 1898

8. AGE: Years: 49 Months: Days: If less than one day ..... hrs. ..... min.

9. Birthplace: Pitt County, North Carolina (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

MOTHER FATHER

12. Name: Abram Galloway

13. Birthplace: Pitt County, North Carolina

MOTHER

14. Maiden name: Maggie Adams

15. Birthplace: Pitt County, North Carolina

18. Informant: Blanco Hardee

Address: Greenville, North Carolina

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-10-48 (month) (day) (year)

Cemetery or crematory: Bymoor

Location: Greenville, N. C.

18. Funeral director: Pitts Bros.

Address: Upper Marlboro, Md.

19. Jan. 10 1948 (Date rec'd by registrar) F. H. Bellingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 1948 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death: Hemorrhage and Shock

Due to: Crushed chest

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 1-10-48

Where did injury occur? Cheltenham (City or town) Prince Georges (County) Md. (State)

Injured at home, farm, industry, public place (where?) Route 301

Means of injury: Passenger in auto in collision (Injured at work?)

23. SIGNATURE: Deputy medical examiner James J. Wood M. D. or other

Address: Upper Marlboro Md. Date signed 1-12-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00777

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

173 38 234

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Prince George's

City or town: Fort Foote

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred: In a field near Fort Foote

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: South Carolina County: .....

City or town: Goldville

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William Alexander Moorhead

3.(b) Social Security Number: .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 4, 1886

8. AGE: Years: 61 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: South Carolina (Town, county, and state)

10. Usual occupation: Vice President

11. Industry or business: Joanna Cotton Mills

FATHER — 12. Name: Walter Moorhead

13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Delilah Jane Whitlock

15. Birthplace: South Carolina

16. Informant: J. B. Hunt

Address: Clinton, S. C.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Jan 14. 1948 (month) (day) (year)

Cemetery or crematory: Clinton

Location: South Carolina

18. Funeral director: F. Gaskts sons

Address: Hyattsville Md.

19. 1/13. 19 48 Amanda Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13, 19 48, at 5:30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Compound fracture of the left leg	
Due to: Compound comminuted fracture of the right leg.	
Other conditions: Crushed pelvis, abdomen, chest and skull	
Universalfirst second and third degree burns of the body	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 1/13/48

Where did injury occur? Fort Foote (City or town) P. G. (County) Md. (State)

Injured at home, farm, industry, public place (where?): In a field

Means of injury: In an airplane crash Injured at work?

Deputy Medical Examiner

23. SIGNATURE: James J. Bond M. D. or other

Address: Forestville, Md. Date signed: 1/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00778

61

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges.

City or town: Maryland Park.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Prince Georges

City or town: Maryland Park.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 109-65th Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Annie Maria Moreland.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed.

6.(b) Name of husband or wife: Benjamin Franklin Moreland

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 6, 1890

8. AGE: Years: 57 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Brandywine, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home.

FATHER
12. Name: William James Thomas
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Martha Elizabeth Windsor
15. Birthplace: Maryland.

16. Informant: Helen Moreland

Address: 109-65th Ave, Maryland Park Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 11. 1948. (month) (day) (year)

Cemetery or crematory: St Thomas Episcopal Cemetery

Location: Croome Md

18. Funeral director: E Gosch's Sons

Address: Hyattsville Md.

19. 1/9 1948 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8 1948, at 2 25 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1947, to August 15 1947

and that I last saw him alive on August 15 1947

	DURATION
Immediate cause of death: Congestive heart failure	15 minutes
Due to: Cardio-vascular-renal disease (hypertension).	5 years
Due to:	
Other conditions: Diabetes Mellitus	3 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William Brannin M. D. or other

Address: Capitol Heights, Md. Date signed: 1/8/48

1/8/48 coroner James S. Boyd notified and consent given for signature of certificate.

W Brannon, MD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

486

00779

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Prince Georges General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Pr. Geo.

City or town: Temple Hills, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. 5800-Temple Hill Rd., S. E. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: SARAH MORGAN

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ----

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): May 22nd, 1885

8. AGE: Years: 62 | Months: | Days: | If less than one day: ... hrs. ... min.

9. Birthplace: Plymouth, Pennsylvania (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Nurse Maid

FATHER — 12. Name: John Morgan; 13. Birthplace: Wales

MOTHER — 14. Maiden name: Margaret Thomas; 15. Birthplace: Wales

16. Informant: Mrs. Dolores M. Allen

Address: 5800-Temple Hill Rd., S. E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 3-1948 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland Maryland

18. Funeral director: Arthur E. Simmons

Address: 2007-Nicholas Ave S.E.

19. Jan 2 1948 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1 1948 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Jan 1 1948 and that I last saw her alive on Dec 31 1947

Immediate cause of death: Adenocarcinoma of Body of uterus with / Pulmonary embolism — DURATION: 2 mo

Due to:

Due to: —

Other conditions: — none of note —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul C Van Natta M. D. or other

Address: Washington D.C. Date signed: Jan 1 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00780

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince George

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos., 2 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 6 mos., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: District Training School
(If outside city or town limits, write RURAL and give nearest town)

Street No. Laurel, Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME MELVIN MOSS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: - - -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 25, 1935

8. AGE: Years	Months	Days	If less than one day
13	0	6	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: child

11. Industry or business: - - -

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: Artimitia Moss (Butler)
15. Birthplace: Washington, D. C.

16. Informant: Artemitia Butler
Address: 4426 Falls Terrace St. Wash. D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feby 1st 1948 (month) (day) (year)

Cemetery or crematory: Paynes Cemetery

Location: Washington D.C.

18. Funeral director: [illegible] (or of King)

Address: 30 H St. N.E.

19. Feb. 1, 1948 Rowland S. Philips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 31 1948 at 2:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 8 1947 to JAN. 31 1948 and that I last saw him alive on JAN. 31 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 mo.
Tuberculous Meningitis	15 da.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 1-31-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The name and age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00781

83a

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days 2 hrs 25 mins
Hospital, institution, or street address where death occurred: Prince Georges General
How long in hospital or institution? 5 days 2 hr. 25 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Cottage City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3720 Parkwood
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Margaret Newman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) August 8, 1869

8. AGE: Years 78 Months 5 Days 17 If less than one day ... hrs. ... min.

9. Birthplace: Indiana (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business
FATHER 12. Name: Jabez Nixon
13. Birthplace: Indiana
MOTHER 14. Maiden name: Charlotte Hinkle
15. Birthplace: Indiana
16. Informant: Hospital records
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/28/48 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Wash. D.C.
18. Funeral director: W W Chaney & Son
Address: Riverdale, Md
19. 1/28 1948 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25 1948 at 7:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1948 to Jan 25 1948 and that I last saw her alive on Jan 25 1948

	DURATION
Immediate cause of death: Cerebral hemorrhage	2 days
Due to: Cerebral arteriosclerosis	yrs.
Due to:	
Other conditions: Bronchopneumonia	15 days

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Aaron Deitz M.D. Leonard Ott M.D. M.D. or other
Address: 4314 Gallatin St Hyattsville Date signed 1/28/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-75M

00782

138

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 19 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 5 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 123 Rose Court, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME
NEWMAN THOMAS D.

3. (b) Social Security Number
578-16-0861

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: - - -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 12, 1890

8. AGE: Years	Months	Days	If less than one day
57	2	23	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: - - -

FATHER
12. Name: Charles Newman
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Annie Vodrey
15. Birthplace: Washington, D. C.

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan 4, 1948 (month) (day) (year)

Cemetery or crematory

Location: to Washington, D. C.

18. Funeral director: Russell M. Henson

Address: 3162 S St. N.W.

19. Jan 4, 1948 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 4, 1948 at 12:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/15, 1947, to 1/4 1948 and that I last saw h~~im~~ alive on 1/4 1948

Immediate cause of death: pulmonary tuberculosis — DURATION: 30 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 1/4/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00783

940

CERTIFICATE OF DEATH

Reg. Dist. No. 745

1. PLACE OF DEATH: Prince George's County

College Park City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 yrs

Hospital, institution, or street address where death occurred: 7013 Wake Forrest Drive

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Pr George's

City or town College Park (If outside city or town limits, write RURAL and give nearest town)

Street No. 7013 Wake Forrest Dr (If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Florence Linthicum Owings

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife David Clark Owings

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 24 - 1857

8. AGE: Years 90 Months 7 Days 26 If less than one day ... hrs. ... min.

9. Birthplace Clarksburg, Md (Howard Co) (Town, county, and state)

10. Usual occupation — Housewife

11. Industry or business —

FATHER 12. Name ~~Unknown~~ Cassaway Linthicum

13. Birthplace Maryland

MOTHER 14. Maiden name ~~Unknown~~ Amanda Noyle

15. Birthplace Maryland

16. Informant Clarence Watson Owings

Address College Park, Md

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 1-23-48 (month) (day) (year)

Cemetery ~~or crematory~~ Pine Grove

Location Mt. Airy, Carroll Co. Md

18. Funeral director C. M. Waltz

Address Winfield, Md

19. Jan 20 1948 James Seay (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 January 1948 at 9 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 Jan 1948 to 20 Jan 1948 and that I last saw him/her alive on 13 January 1948

Immediate cause of death Hypostatic Pulmonary Congestion — DURATION

Due to Coronary Thrombosis

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. H. Etienne M. D. ~~or other~~

Address Berwyn, Md Date signed 1-20-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

131a 00784

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Capitol Heights (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years

Hospital, institution, or street address where death occurred: 426 - 62nd Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Capitol Heights (If outside city or town limits, write RURAL and give nearest town)

Street No. 426 - 62nd Place (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Angiolina Palma

3.(b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Ralph Palma

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Jan 9, 1876

8. AGE: Years 72 Months Days If less than one day hrs. min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER 12. Name: Joseph Orange

FATHER 13. Birthplace: Italy

MOTHER 14. Maiden name: Theresa Miller

MOTHER 15. Birthplace: Italy

16. Informant: Anthony Palmer

Address: 426 - 62nd Place, Capitol Hts

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28 48 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md

18. Funeral director: S. S. Chambers Co

Address: 517 14th Street S.E. Wash. D.C.

19. Jan. 26 1948 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 25 1948 at 3 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death: Acute Congestive heart failure

Due to: Cardiovascular renal disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner M.D. or other

Address: Greenbelt Md Date signed 1-25-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

131a 00785

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George's
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1-4 years
Hospital, institution, or street address where death occurred:
608-49th Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Prince George's
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 608-49th
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
George Pappas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6.(b) Name of husband or wife: Aphrodite Pappas
6.(c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.): March 7, 1881

8. AGE: Years	Months	Days	If less than one day
66			hrs. min.

9. Birthplace: Greece (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Baker

FATHER
12. Name: Athanasios Pappas
13. Birthplace: Greece

MOTHER
14. Maiden name: Vasiliki Paloyannis
15. Birthplace: Greece

16. Informant: Vasiliki Pappas
Address: 608-49th Ave., Capitol Heights
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-8-48 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md.
18. Funeral director: W. W. Chambers Co
Address: 1400 Chapin St. N.W.
19. Jan 7, 1948 (Date rec'd by registrar) Carrie F. Campbell. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6, 1948, at 8 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other
Address: Upper Marlboro Md. Date signed 1-6-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legally. Correct age is especially important.

VS A15 - 9 45-15M

00783

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 19 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1521 Rhode Island Ave., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME
Parlette, Charles J.

3.(b) Social Security Number
577-30-4544

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Margaret Toohill

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 16, 1883

8. AGE: Years	Months	Days	If less than one day
64	10	10	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Bookkeeper

11. Industry or business: —

FATHER
12. Name: Thomas Edgar Parlette
13. Birthplace: ?

MOTHER
14. Maiden name: Grace Lee Gosnell
15. Birthplace: Carroll County, Maryland

16. Informant: Deceased
Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 1-28-48. (month) (day) (year)
Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18. Funeral director Geo L. Berger Jr
Address 1512 Hollins St Balto Md

19. Jan 26 1948 (Date rec'd by registrar) Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26, 1948 at 9.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6, 1947 to Jan. 26, 1948 and that I last saw him alive on Jan. 26, 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 7 mo.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D. M. D. or other

Address Glenn Dale Md. Date signed 1/26/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00787

111c

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: East Riverdale, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: East Riverdale,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5802 66th Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph A. Prowinsky

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	separated

6.(b) Name of husband or wife: Ethel M.

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): May 3, 1879

8. AGE: Years: 68 Months: 7 Days: 19 If less than one day: hrs. min.

9. Birthplace: Hika, Wisconsin (Town, county, and state)

10. Usual occupation: Retired- Government Employee

11. Industry or business: (Finance)

FATHER — 12. Name: August Prowinsky

13. Birthplace: Germany

MOTHER — 14. Maiden name: Mary Mantei

15. Birthplace: Germany

16. Informant: Gertrude Mary Upczak

Address: 5802 66th Avenue-East Riverdale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 24, 1948 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cemetery

Location: Prince Georges County, Md.

18. Funeral director: The S. W. Hines Company

Address: 2901 14th St., N.W. - Wash. D.C.

Jan 22 1948 James Seery

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 22 1948 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-14- 1947 to 1-22 1948 and that I last saw him alive on 1-22- 1948

Immediate cause of death	DURATION
Pulmonary Edema	3 wks
Due to: Cardiac Failure	3 mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Stephen Fishman MD M. D. or other

Address: 2924 Nichols Place SE Date signed: 1-22-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00788

938

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince George

City or town: District Hgts.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 21 yrs 205 Wash. Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Dist. Hgts.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 205 Wash. Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: JAMES MARCUS PUMPELLY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: ZEULAH A. PUMPELLY

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 5th 1876

8. AGE: Years	Months	Days	If less than one day
72			hrs. min.

9. Birthplace: KENTUCKY (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Real Estate

FATHER 12. Name: —

13. Birthplace: —

MOTHER 14. Maiden name: —

15. Birthplace: —

16. Informant: Charles Pumpelly

Address: 205 Wash Blvd. Dist Hts.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-17-48 (month) (day) (year)

Cemetery or crematory: Wash. Natl.

Location: Suitland Md

18. Funeral director: W. W. Chambers Co.

Address: 517 11th St S.E.

19. Jan. 16 1948 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 14 1948 at 7 25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to Jan 14 1948 and that I last saw him alive on Jan. 12 1948

Immediate cause of death	DURATION
Coronary vascular accident	15 min.
Due to: Hypertensive arterio-sclerotic heart disease	10 years
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Sidney W. Lowry M.D. M. D. or other

Address: 601 Wash Blvd. Dist Heights, Md

Date signed: Jan. 14 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00789

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 5 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 5 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 453 K. Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Elizabeth Ramsey

3. (b) Social Security Number 579-32-7510

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph C. Ramsey

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): January 31, 1929

8. AGE: Years	Months	Days	If less than one day
18	11	22	hrs. min.

9. Birthplace: Waynesboro, Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: - -

FATHER
12. Name: Amos Brydge
13. Birthplace: Glenhurst, Virginia

MOTHER
14. Maiden name: Ruby Truslow
15. Birthplace: Wintergreen, Virginia

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 26 1948 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington County Virginia

18. Funeral director: W. W. Chambers Co.

Address: 517-11th St. S.E. Washington, D.C.

19. Jan 23, 1948 (Date rec'd by registrar) Rowland J. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 22 1948 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 6 1947 to Jan 22 1948 and that I last saw h. alive on Jan 22 1948

Immediate cause of death	DURATION
Thoracoplasty Operation	
Due to: Pulmonary Tuberculosis	6 mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op. 1-20-48 Exploration 1-22-48

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 1/22/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00790

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

Reg. Dist. No. 445

1. PLACE OF DEATH:

County: Prince Georges

City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4108- Rainier Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George E. Reier

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife: Laura Reier

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 9,

8. AGE:

Years	Months	Days	If less than one day
78			..... hrs. ..... min.

9. Birthplace: Greenwood, Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Adam Reier
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Edward E. Reier

Address: 4108 - Rainier Ave. Mt. Rainier, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 19, 1948 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Colmar Manor, Md.

18. Funeral director: Wm. J. Nalley

Address: 3200 - R.I. Ave. Mt. Rainier, Md.

18 Jan 18 1948 James Seery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 16 1948 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1947 to Jan. 16 1948 and that I last saw h. LIV alive on January 14 1948

Immediate cause of death	DURATION
Natural causes due to old age	
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Prostatectomy

Date of op. Feb. 1947

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D S Chapman M.D.
M. D. or other

Address: 4118-30th St. Mt Rainier Date signed: 1-17-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00791

462

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: PRINCE GEORGE'S

City or town: CHEVERLY

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, Institution, or street address where death occurred: PRINCE GEORGE'S GENERAL HOSPITAL

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4610 Kilbourne Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Esther Richmond.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Dec. 19, 1879

8. AGE: Years: 68 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name

13. Birthplace: Russia

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Russia

16. Informant: Hospital Records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan 11, 1948 (month) (day) (year)

Cemetery or crematory

Location: New York City, N.Y.

18. Funeral director: B. Mennenly & Son

Address: 3501-14th St. N.W. Wash. D.C.

19. Jan 11 1948 (Date rec'd by registrar) Amanda L. Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 10 1948 at 10:30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 1947 to Jan 10 1948 and that I last saw h. alive on Jan 18 1948

	DURATION
Immediate cause of death: Cerebral vasc. accident	3 days
" " "	4 wks
Due to: General arteriosclerosis	
Due to:	
Other conditions: Cancer of sigmoid (resected)	6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: Cancer sigmoid prior to recent admission

Autopsy results: refused

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Aaron Deitz, M.D. Leonard Rose, M.D.

M. D. or other

Address: 4314 Gallatin Hyattsville Date signed: Jan 10, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00792

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: College Park Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: College Park Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4504 Guilford st
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Maria Rickl

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: John Rickl
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): march 10, 1881

8. AGE: Years	Months	Days	If less than one day
66 67	10	21	..... hrs. ..... min.

9. Birthplace: Pellichsdorf Austria (Town, county, and state)
10. Usual occupation: at home
11. Industry or business
FATHER 12. Name: Johanna Pigatt
13. Birthplace: Austria
MOTHER 14. Maiden name: — Smidt
15. Birthplace: Austria
16. Informant: Mrs Hermine Prahl
Address: College Park Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 3, 1948 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: suitland Md
18. Funeral director: F. Gasch's sons
Address: Hyattsville Md.
19. Feb 1 1948 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31, 1948 at 8-15 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30, 1947 to January 31, 1948 and that I last saw her alive on January 31, 1948

Immediate cause of death	DURATION
Coronary thrombosis	10 hrs
Due to: Coronary sclerosis	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hans Wodak, M.D. M. D. or other
Address: 30-B Ridge Rd, Greenbelt, Md Date signed: 1-31-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00793

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days 8 hrs. 45 mins

Hospital, institution, or street address where death occurred: Prince Georges General

How long in hospital or institution? 19 days 8 hrs. 45 mins

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Bladensburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4715 Annapolis Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Carl William Rohrbach

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife: /

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 8, 1885

8. AGE: Years	Months	Days	If less than one day
62	5	21	____ hrs. ____ min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: carpenter

11. Industry or business

FATHER — 12. Name: John Rohrbach

13. Birthplace: Chicago Ill.

MOTHER — 14. Maiden name: Anna Constantine

15. Birthplace: Bladensburg, Md.

16. Informant: Hosp. Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 31. 1948 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Bladensburg Md

18. Funeral director: F. Gaschsons

Address: Bladensburg Md

19. 1/31 1948 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29 1948 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-10 1948 to 1-30 1948 and that I last saw him alive on 1-30 1948

Immediate cause of death: Myocardial degeneration with dilatation

Due to:

Due to:

Other conditions: Hypertensiveness

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results: Seen

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Irvin M. Grossgreen M.D. M. D. or other

Address: Mt. Rainier, Md. Date signed: 1-30-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct page is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

173 00794 NB

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Camp Springs (Andrews Air Field)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Several times each week

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County: Arlington

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 824 S. Arlington Mill Road
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME

RYERSON, CHARLES ROBERT

3.(b) Social Security Number 224-12-4223

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Cora Ryerson (nee Glassner) 6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): February 19 1920

8. AGE:

Years	Months	Days	If less than one day
27	11	-0-	hrs. min.

9. Birthplace: Oakland California (Town, county, and state)

10. Usual occupation: Insurance Salesman

11. Industry or business

FATHER

12. Name: Charles Settle Ryerson

13. Birthplace: Kansas City Missouri

MOTHER

14. Maiden name: Jean Mitchell

15. Birthplace: Mc Coole Maryland

16. Informant: Hosp Records

Address: Andrews Fld Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/22/48 (month) (day) (year)

Cemetery or crematory: Arlington Mem

Location: Arlington Va

18. Funeral director: R.R. Chambers Co

Address: 519-11 SW DC

19. Jan 19 1948 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 January 1948 at 1358 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Crushing injuries to chest and head and possible Fracture of neck	
Due to: Aircraft Accident	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 18 Jan 48

Where did injury occur? Camp Springs (City or town) Prince Georges (County) Md. (State)

Injured at home, farm, industry, public place (where?) Andrews Air Field

Means of injury: Airplane Accident Injured at work? No

23. SIGNATURE: William J. Miller
WILLIAM J. MILLER Capt. MC
M.D. or other

Address: Andrews Air Fld Date signed: 18 Jan 48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

173 S 00795

Reg. Dist. No. 234

1. PLACE OF DEATH:

County: Prince George's

City or town: Fort Foote

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred:

In a field near Fort Foot.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: New York County:

City or town: Great Neck

(If outside city or town limits, write RURAL and give nearest town)

Street No. 126 Hicks Lane

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Paul John Saltanis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha Saltanis

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 23, 1912

8. AGE: Years	Months	Days	If less than one day
35			hrs. min.

9. Birthplace: Treveskyn, Pa.

(Town, county, and state)

10. Usual occupation: Pilot

11. Industry or business: Eastern Air Lines

FATHER

12. Name: Adam Sultanis

13. Birthplace: Unknown

MOTHER

14. Maiden name: Sofie ?

15. Birthplace: Pennsylvania

16. Informant: Bertha Sultanis

Address: 126 Hicks Lane, Great Neck, N. Y.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Jan 14, 1948 (month) (day) (year)

Cemetery or crematory: Penn station

Location: New York

18. Funeral director: F. Gaecta sons

Address: Hyattsville Md.

19. 1/14 1948 Amanda Downey Registrar

(Date rec'd by registrar) Mrs. Elton Dow

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 1948 at 5:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Fracture of left femur and ankle	
Due to: Fracture of the skull	
Crushed chest	
Other conditions: Multiple abraisions of the extremeties, head and body	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 1/13/48

Where did injury occur? Fort Foote (City or town) P. G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) In a field.

Means of injury: In an airplane crash Injured at work? Yes

23. SIGNATURE: James S. Bond M. D. or other

Deputy Medical Examiner

Address: Forestville, Md. Date signed 1/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct page is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for the change of age is shown on FILM No. G 114 FEB 11 1948

00796

173

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:

County: Prince George's

City or town: Fort Foote (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred: In a filed near Fort Foote

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: New Jersey County:

City or town: Bayonne (If outside city or town limits, write RURAL and give nearest town)

Street No.: 27 West 33rd (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ralph Berry Sanborn Jr.

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 17, 1918

8. AGE: Years: 29 ~~31~~ Months: 1 Days: 26 If less than one day: hrs. min.

9. Birthplace: Bayonne (Town, county, and state)

10. Usual occupation: Copilot

11. Industry or business: Eastern Air Lines

FATHER 12. Name: Ralph B. Sanborn Sr.

FATHER 13. Birthplace: Massachusetts

MOTHER 14. Maiden name: Hazel Ramsdell

MOTHER 15. Birthplace: Massachusetts

16. Informant: Ralph B. Sanborn Sr.

Address: 27 West 33rd Street, Bayonne, N. J.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Jan 13, 1948 (month) (day) (year)

Cemetery or crematory: Brookside Cemetery

Location: Englewood N. J.

18. Funeral director: F. Gaeta Sons

Address: Hyattsville Md.

19. 1/13 1948 (Date rec'd by registrar) Amanda Downey Mrs. Alton Davis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 1948 at 5:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Crushed skull	
Due to:	
Other conditions: Multiple abraisions of the hands and legs.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 1/13/48

Where did injury occur? Fort Foote (City or town) P. G. (County) Md. (State)

Injured at home, farm, industry, public place (where?): In a field

Means of injury: In a plane crash Injured at work?

23. SIGNATURE: James J. Bond M. D. or other

Deputy Medical Examiner

Address: Forestville, Md. Date signed: 1/13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1142 00797

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:
County: Prince Georges
City or town: Rural - Rosaryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Nov 1942.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo
City or town: Rural - Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.: The Rosaryville
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward Patterson Sanford

3.(b) Social Security Number: —

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Hilda Hannall Sanford
6.(c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): July 29, 1877

8. AGE: Years: 50 Months: 5 Days: 17 If less than one day: hrs. min.

9. Birthplace: Philadelphia Penn (Town, county, and state)
10. Usual occupation: Economist
11. Industry or business: U.S. Gov't.
12. Name (FATHER): Rufus
13. Birthplace: Conn
14. Maiden name (MOTHER): Martina Talmadge Patterson
15. Birthplace: York.
16. Informant: Mrs. Hilda Sanford.
Address: Upper Marlboro, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1 (month) 19 (day) 48 (year)
Cemetery or crematory: Trinity Episcopal
Location: Upper Marlboro Md
18. Funeral director: Ritchie Bros
Address: Upper Marlboro Md
19. Jan 17 1948 (Date rec'd by registrar) T. H. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 Jan 1948 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1947 to 16 Jan 1948 and that I last saw h. alive on 16 Jan 1948

Immediate cause of death	DURATION
Congestive Heart Failure	14 hours
Due to: Pulmonary Kochi's Bacillus Infection	Unk.
Due to: —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert B. Lanier M.D. (M. D. or other)
Address: Upper Marlboro, Md. Date signed: 18 Jan 48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

20
42
23
77

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00798

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 27 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 723 G. St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME
LEE DAVID SHAW

3.(b) Social Security Number
240-22-8840

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Alease McDaniel Shaw

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): February 7, 1924

8. AGE: Years	Months	Days	If less than one day
23	10	29	hrs. min.

9. Birthplace: Maxton, North Carolina
(Town, county, and state)

10. Usual occupation: Stacker, Warehouse

11. Industry or business: - - -

FATHER
12. Name: Luke Shaw
13. Birthplace: Dulon, South Carolina

MOTHER
14. Maiden name: Bessie Wilkerson
15. Birthplace: Maxton, North Carolina

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 7/48 (month) (day) (year)

Cemetery or crematory

Location: Washington DC.

18. Funeral director: Frazier Funeral Home Co

Address: 389 Rhode Island Ave N.W.

19. Jan. 7, 1948 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 5, 1948 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 8, 1947 to Jan. 5, 1948 and that I last saw him alive on Jan. 5, 1948.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 1/5/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

CERTIFICATE OF DEATH

B 007945

Reg. Dist. No. 345

1. PLACE OF DEATH:

County: Prince George's

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead on arrival

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: West Virginia County: Putnam

City or town: Poca

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Virginia Seigman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years 25 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Poca W. Va. (Town, county, and state)

10. Usual occupation: Mill worker

11. Industry or business

FATHER 12. Name: Marshall Seigman

13. Birthplace: W. Va.

MOTHER 14. Maiden name: Clara Smith

15. Birthplace: W. Va.

16. Informant: Ray Boggess

Address: Nitro, W. Va.

17. (Burial, cremation, or removal, Which?) transportation Date thereof: Feb 1, 1948 (month) (day) (year)

Cemetery or crematory: Poca

Location: West Va

18. Funeral director: F. Gaede Long

Address: Hyattsville Md.

19. Feb 1 1948 James Severy (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31 1948, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Crushed chest	
Fractured skull	
Due to:	
Other conditions: Fracture of right humerus	
multiple abrasions to face	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 1-31-48

Where did injury occur? Muirkirk (City or town) P.G. (County) Md (State)

Injured at home, farm, industry, public place (where?) Route #1

Nature of injury: injured in car that injured driver attended

Deputy medical examiner

23. SIGNATURE: [illegible] M. D. or other

Address: Forestville Md Date signed 1-31-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00800

936

Reg. Dist. No. 142

1. PLACE OF DEATH:

County: Prince George

City or town: Dist. Heights Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Geo

City or town: Dist Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 601-E St. S.E. Washington 19 DC

(If rural, give LOCATION)

2.(a) If veteran, name war: — none —

3.(a) FULL NAME: Freda Smith

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	W	Widowed

6.(b) Name of husband or wife: Lorenzo Smith (Deceased) 6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Apr 13 1872

8. AGE: Years 75 | Months — | Days — | If less than one day ... hrs. ... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Christian Schrack

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Germany

16. Informant: Elz. Anna Hamilton

Address: 601 E St. Dist Heights, Md. Washington 19 DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 13, 48 (month) (day) (year)

Cemetery or crematory: Washington National

Location: Suitland Md.

18. Funeral director: W. W. Chambers Co.

Address: 517-11th St. S.E.

19. Jan. 13 1948 (Date rec'd by registrar) Carrie F. Campbell, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 13 1948 at 8:35 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 8 1948 to Jan 13 1948 and that I last saw her alive on Jan 12 1948

Immediate cause of death	DURATION
Acute Congestive Heart failure	6 hrs
Due to: Cerebral Hemorrhage with Paralysis left body	4½ days
Due to: General arteriosclerosis	Lifetime
Other conditions: Large Ventral hernia (Post Operative)	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Unknown - Operation at Albany New York Date of op. 5 yrs ago

Autopsy results: Unknown

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of: —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Paul Van Yatta M. D.

Address: Washington 19 D.C. Date signed: Jan 13 1948

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

00801

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day 18 hrs. 30 mins.

Hospital, institution, or street address where death occurred: Prince Georges General

How long in hospital or institution? 1 day 18 hrs. 30 mins

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4700 44th Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Merton Snyder

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Ena Mae Snyder

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): February 19, 1872

8. AGE: Years	Months	Days	If less than one day
75	11	7	hrs. min.

9. Birthplace: Illinois (Town, county, and state)

10. Usual occupation: retired

11. Industry or business

FATHER

12. Name: unknown

13. Birthplace: New York

MOTHER

14. Maiden name: unknown

15. Birthplace: New York

16. Informant: Hospital Records

Address: Cheverly Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Jan 28, 1948 (month) (day) (year)

Cemetery or crematory: Lee Funeral Home

Location: 4th mass ave N.E. Washington DC

18. Funeral director: F Goschie Lone

Address: Hyattsville Maryland

19. 1/28 1948 Amanda Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26 1948 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-24 1948 to 1-26 1948 and that I last saw h. alive on 1-25 1948

Immediate cause of death	DURATION
Arteriosclerotic Cardiac Vascular Disease	2 yrs ?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: U B Bennett M.D. M. D. or other

Address: Nat. Kaiser Hosp. Date signed: 1-26-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Pr. George
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 days
Hospital, Institution, or street address where death occurred: Pr. Geo. Genl Hosp.
How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4225 30th St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Stanton, Charles E

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	m

6.(b) Name of husband or wife: Mary L. Stanton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 13 - 1869

8. AGE: Years 78 | Months 6 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace: Missouri (Town, county, and state)
10. Usual occupation: Proof Reader & Printer
11. Industry or business

FATHER
12. Name: Wm. Stanton
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mary Ann Blanchard
15. Birthplace: North Carolina

16. Informant: Mary S. Stanton
Address: 4225 - 30th St. Mt. Rainier,
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 2, 1948 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Colmar Manor, Md.
18. Funeral director: Wm. J. Nalley
Address: 3200 - R.I. Ave. Mt. Rainier, Md
19. Feb 1 1948 (Date rec'd by registrar) A Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-30 1948 at 3 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-29 1947 to 1-30 1948 and that I last saw h~~im~~ alive on 1-29 1948

Immediate cause of death	DURATION
Pulmonary Embolism C Collapse of Lower Lobe Right Lung	3 mo.
Due to: Coronary Heart Disease C 2 attacks Coronary Occlusion	6 yrs.
Due to:	
Other conditions: Prostatectomy 3 Prostatic Colon	5 yrs?

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: See above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W B Mayne M.D. M. D. or other
Address: Mt. Rainier Md Date signed 1-30-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00803

93e

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred: Prince Georges General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)

Street No. 200 Main Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Edward Swoffield

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Laura J. Swoffield

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 26, 1891

8. AGE: Years: 56 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business: ~~Barber~~

FATHER 12. Name: Harry Swoffield

FATHER 13. Birthplace: England

MOTHER 14. Maiden name: Katherine Gresser

MOTHER 15. Birthplace: Baltimore, Md

16. Informant: Mrs Laura J. Swoffield

Address: 200 Main Street, Laurel, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 22, 1948. (month) (day) (year)

Cemetery or crematory: Ivy Hill Cemetery

Location: Laurel Md.

18. Funeral director: J. Arthur Walters

Address: 505 Nash Blvd., Laurel Md.

19. 1/21 1948 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1948 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Toxemia

Due to: Toxic nephritis, hepatitis, and myocarditis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner for Boyd (M. D. Coroner)

Address: Upper Marlboro Md. Date signed 1-19-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If more space is needed use back page. MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

138 00804

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: Hampshire Knolls (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Hampshire Knolls (If outside city or town limits, write RURAL and give nearest town)

Street No. 6409 Elliott Pl. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: HARRY TALBOTT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Gertrude O. Talbott

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 11, 1901

8. AGE: Years: 46 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Wash. D.C. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: —

FATHER — 12. Name: Harry W. Talbott

FATHER — 13. Birthplace: Wash. D.C.

MOTHER — 14. Maiden name: Lelia McCleary

MOTHER — 15. Birthplace: Va.

16. Informant: Gertrude B. Talbott

Address: above

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 12, 1948 (month) (day) (year)

Cemetery or crematory: Carbondale, Pa.

Location

18. Funeral director: W. Warren Talbott

Address: 3619-14th St N.W. D.C.

19. Jan. 10 1948 (Date rec'd by registrar) Mrs. Jas. Severe (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/10 1948 at 12:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1934 19.. to 1/10 1948 and that I last saw him alive on 1/9 1948

Immediate cause of death	DURATION
Chronic Myocarditis	1 yr
Due to: Pulmonary Tuberculosis	4 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: ..... Injured at work?

23. SIGNATURE: R. Leonards M.D. (M. D. or other)

Address: 5801-13th St. N.W. Wash. D.C. Date signed: 1/10/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 00805

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: PRINCE George's !

City or town: Spring field –
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Spring field
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Ethel Elizabeth Taylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George E. Taylor

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): August. 20, 1891

8. AGE: Years	Months	Days	If less than one day
56			hrs. ... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER 12. Name: Eugene windsor
13. Birthplace: Md

MOTHER 14. Maiden name: Fannie Ferguson
15. Birthplace: Md

16. Informant: MR. George E. Taylor
Address: Springfield Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 8. 1948 (month) (day) (year)

Cemetery or crematory: Holy Trinity Cemetery

Location: Collington Md

19. Funeral director: L. Gasche Sons

Address: Hyattsville Md.

19. 1/7 1948 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5 1948 at 5:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19.. to Jan. 5 1948 and that I last saw her alive on 11/5/47 19..

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Hypertrophy Cardiac – Vascular Disease	15 yrs
Due to: Obesity & Arteriosclerosis	20 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. M. Warren M.D. M.D. or other

Address: Laurel Md Date signed 1/6/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a 00806

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Mt Rainier

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred: 3818 - 31st Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Mt Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3818 - 31st Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Daniel Samuel Tetlow

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife: Winifred Tetlow

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1861

8. AGE: Years: 67 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER

12. Name: Samuel Tetlow

13. Birthplace: Maryland

MOTHER

14. Maiden name: Sarah Gyton

15. Birthplace: Maryland

16. Informant: John E. Sullivan

Address: 1483 Newton St N.W. Wash D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/24/48 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Wash. D.C.

18. Funeral director: Wm J. Malloy

Address: 3200 - R.I. Ave. Mt Rainier

19. Jan 24 1948 James Severy (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1948 at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: deputy medical examiner (M. D. or other)

Address: Forestville Md Date signed 1-21-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243. 00847

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 20 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 4 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1202 Que St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: EULA TURNER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Robert Turner

6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): September 26, 1911

8. AGE: Years	Months	Days	If less than one day hrs.	min.
36	36	3	11	

9. Birthplace: Federal, North Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: - - -

FATHER
12. Name: Sam Reed
13. Birthplace: ? North Carolina

MOTHER
14. Maiden name: Rachel Patterson
15. Birthplace: ? North Carolina

16. Informant: Deceased

17. Address: Removal (Burial, cremation, or removal. Which?) Date thereof: Jan 7-1948 (month) (day) (year)

Cemetery or crematory:

Location: Washington - D.C.

18. Funeral director: Malone + Sehy Inc.

Address: 404 - R St. N.W.

19. Jan 7, 1948 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 6 1948 at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUG. 16 1947 to JAN. 6 1948 and that I last saw him alive on JAN. 6 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 13 mo.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: 1-6-48

00808

169

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George's

City or town: College Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, Institution, or street address where death occurred: Fordham Road and B and O tracks

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: North Carolina County: Wake

City or town: Raleigh

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1514 Fairview Road

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME Walter Jackson Vereen

3.(b) Social Security Number

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): march 27, 1926

8. AGE: Years: 21 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Raleigh, North Carolina (Town, county, and state)

10. Usual occupation: Student

11. Industry or business: University of Maryland

FATHER

12. Name: Joseph Greenleaf Vereen

13. Birthplace: South Carolina

MOTHER

14. Maiden name: Essie Moody

15. Birthplace: Kentucky

16. Informant: Elinor Vereen

Address: 5 Russell Rd, Apt 2, Alexandria, Md

17. transportation (Burial, cremation, or removal. Which?) Date thereof Jan 8, 1948 (month) (day) (year)

Cemetery or crematory: Raleigh

Location: North Carolina

18. Funeral director: F. Gesche's sons

Address: Hyattsville Md.

19. Jan 7 1948 (Date rec'd by registrar) Mrs Jas Devere Registrar Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7 1948, at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Hemorrhage and shock	
Due to: multiple crushing injuries to body	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 1/7/48

Where did injury occur? College Park (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) B & O RR tracks

Means of injury: Railroad struck by train Injured at work?

23. SIGNATURE: James J. Bagley M. D. or other Deputy Medical Examiner

Address: Forestville Md Date signed 1-7-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

173 JB 00809

Reg. Diat. No. 334

1. PLACE OF DEATH:
County: Prince George's
City or Town: Fort Foote
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred:
In a field near Fort Foote
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: South Carolina County:
City or town: Clinton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME
Shelburne Morton Warner

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): October 10, 1913
8. AGE: Years: 34 Months: Days: If less than one day: hrs. min.
9. Birthplace: Shelbyville, Tenn. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
FATHER 12. Name: Ed. Warner
13. Birthplace: Tenn.
MOTHER 14. Maiden name: Cora Jones
15. Birthplace: Tenn.
16. Informant: Cora Warner
Address: Shelbyville, Tenn.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 14, 1948 (month) (day) (year)
Cemetery or crematory: Shelbyville
Location: Tenn
18. Funeral director: F. Gische Sons
Address: Hyattsville Md
19. 1/14 1948 (Date rec'd by registrar) Amanda Downey Mrs. Alton Davis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 1948 at 5:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19
Immediate cause of death: Hemorrhage and shock DURATION
Due to: Multiple and compound fractures of the right leg
Due to: Compound fracture of the skull
Other conditions: Universal first, second and third degree burns of the body
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 1/13/48
Where did injury occur? Fort Foote (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) In a field
Means of injury: In an airplane crash Injured at work?
Deputy Medical Examiner
23. SIGNATURE: James J. Bond M. D. or other
Address: Forestville, Md. Date signed 1/13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

00810

932

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Geo. 6

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: md. County: Pr. Geo. 6

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4613 Madison St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edward Lee Whittington

3.(b) Social Security Number

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: Isabelle V. Whittington

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Jan 14 - 1858

8. AGE: Years: 89 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Jefferson Co. W. Va. (Town, county, and state)

10. Usual occupation: Night watchman, retired

11. Industry or business

FATHER

12. Name: Geo. Whittington

13. Birthplace: W. Va.

MOTHER

14. Maiden name: unknown

15. Birthplace: W. Va.

16. Informant: Chester Whittington

Address: Martinsburg. W. Va.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 1 - 6 - 48 (month) (day) (year)

Cemetery or crematory: New Norborne Cem.

Location: Martinsburg W. Va.

18. Funeral director: W. W. Chandler

Address: Riverdale Md

19. Jan 3 1948 (Date rec'd by registrar) Jno Jos Serue Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3-48 19 ... at 11 15 a m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30 1947 to Jan 3 1948 and that I last saw him alive on Dec 30 1947

Immediate cause of death: Myocarditis

Due to: Senility

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: Duncan Hagan M. D. or other

Address: Hyattsville Md Date signed 1-4-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00811

1310

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hour

Hospital, Institution, or street address where death occurred: Eugene Leland Memorial Hospital

How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5208-43rd Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME Robert Rice Williams

3.(b) Social Security Number 579-14-3194

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Adar Williams

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1868

8. AGE:

Years	Months	Days	If less than one day
80	3	14	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Book Binder

11. Industry or business: W. F. Lowdermilk & Son

FATHER

12. Name: Albert ? Williams

13. Birthplace: Wash., D. C.

MOTHER

14. Maiden name: Selina Rice

15. Birthplace: Wash., D. C.

16. Informant: Mrs. Alice Grimes

Address: 5208-43rd Ave. Hyatts. Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Jan 8/1948 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md

18. Funeral director: F. Gaeche Sons

Address: Hyattsville Md.

Jan 8 1948 James Sevey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7, 1948 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
acute pulmonary edema	
acute Right side heart failure	
Due to: Cardiovascular-renal disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Deputy medical Examiner James E. Ford M. D. or other

Address: Anacostia Md. Date signed 1-7-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00812

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 29 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 months, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 53 Fenton Court, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME LUCILLE WOOD

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Percy Wood

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): June 25, 1918

8. AGE: Years	Months	Days	If less than one day
29	7	3	hrs. min.

9. Birthplace: Linconeton, Georgia
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: - - -

FATHER
12. Name: James Edwards
13. Birthplace: Linconeton, Georgia

MOTHER
14. Maiden name: Riela Dooley
15. Birthplace: Linconeton, Georgia

16. Informant: Deceased
Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Jan. 29 1948 (month) (day) (year)

Cemetery or crematory: Payne Cemetery

Location: to Washington, D.C.

18. Funeral director: St. Joseph Funeral Home

Address: 306 L St. N.W. Wash., D.C.

19. Jan. 29, 1948 (Date rec'd by registrar) Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany 28th 1948 at 10 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 1947 to Jany 28th 1948 and that I last saw her alive on Jany 28th 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 7 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)

Address: Glenn Dale, Md. Date signed: 1/28/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

00813

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 4 mos., 5 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 yrs., 4 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 922 - F. Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME ARTHUR WYMAN

3.(b) Social Security Number 577-09-0310

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Ida Wyman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 3, 1882

8. AGE: Years	Months	Days	If less than one day
65	6	15	hrs. min.

9. Birthplace: Syracuse, New York
(Town, county, and state)

10. Usual occupation: Guard

11. Industry or business: - - -

FATHER
12. Name: Newton Wyman
13. Birthplace: Syracuse, New York

MOTHER
14. Maiden name: Bell Lewis
15. Birthplace: Syracuse, New York

16. Informant: Deceased

Address

17. Removed (Burial, cremation, or removal. Which?) Date thereof 1 20 48 (month) (day) (year)

Cemetery or crematory

Location: Wash. D.C.

18. Funeral director: H. W. Chambers Co.

Address: 8072 - M. St. N.W.

19. Jan 20, 1948 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 18 1948 at 11 25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 12 1945 to JAN. 18 1948 and that I last saw h. alive on JAN. 18 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 4 yr.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 1-18-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M